KANSAS DEPARTMENT FOR AGING & DISABILITY SERVICES

Application for Reinstatement
Speech-Language Pathology/Audiology

A Speech-Language Pathology/Audiology license may be reinstated upon meeting requirements of KSA 65-6506(c) and KAR 28-61-7. Please complete this application documenting department approved continuing education, return it with $270.00 reinstatement fee.

License #: _____ Expired: _____

Name: _____
Last First Middle (Other last name used)

Address: _____

City _____ State _____ Zip _____

Social Security Number _____

Work Phone: (____) _____ Home Phone (___)_____

RECORD OF CONTINUING EDUCATION CLOCK HOURS

Last licensure period in Kansas—from _____ to _____

Record program approval number if program was prior approved by KDADS, title, and total clock hours per program. For programs not prior approved, complete all columns except the approval number column. If reinstating within five years of the expiration date, submit evidence that you have accumulated, within the past two calendar years before the date of application for reinstatement, 20 contact hours of continuing education. You must attach verification of attendance for all prior approved programs listed. (If license has lapsed more than five years, please refer to the "Instructions for Reinstatement" sheet.)

Approval Number	Program Title	Date	Hours

(Please complete the remainder of the application on the back of this page.)

Disciplinary Action—This information is required under Kansas law: KSA 65-3503(a)
Has any license, certification, or registration issued by Kansas or another state or entity been denied, refused for renewal, suspended, revoked or subjected to any other disciplinary action? **Y/N**
If YES, please explain:

_____

_____

_____

Have you ever been convicted of a crime by any court (including Kansas), or any federal court of the United States? **Y/N** If YES, please indicate:

Date of Conviction: _____

City, County and Sate of Conviction: _____

Crime of which convicted: _____

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the department to verify any information provided in this application and attachments. I understand that the application fee is non-refundable should I not meet licensure qualifications.

☞ **NOTE: Applicant signature must be notarized.**

_____ _____

Signature of Applicant Date

SUBSCRIBED AND SWORN TO before me, the undersigned authority,
on this _____ day of _____, 201_____

_____

(Notary Public Signature)

My appointment expires: _____

Submit applications, supporting documents and fee to:

Health Occupations Credentialing
612 S Kansas Ave
Topeka, KS 66603-3404